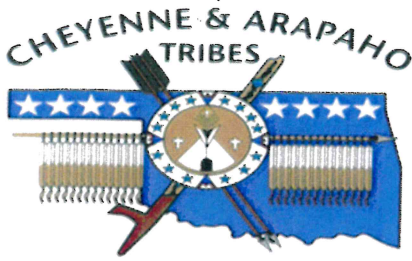


# NATIVE AMERICAN CAREGIVER PROGRAM ELDER CAREGIVER APPLICATION

## *Our Mission:*

*The Native American Caregiver Program's goal is to provide a comprehensive, coordinated, and cost effective system of long-term care in aiding family caregivers caring for tribal elders to maintain a healthy, semi-independent lifestyle in their own homes and communities, as well as providing valuable resources to tribal grandparents caring for grandchildren.*



## Native American Caregiver Program Title VI- Part C Program Information

10331 N. 2274 Rd.  
Clinton, Ok 73601  
Office: (580)331-2351  
Fax: (405)422-8205

*The Cheyenne and Arapaho Native American Caregiver Program is a federal program funded through the Administration on Aging, Title VI-Part C.*

The NAC Program benefits family members caring for their elders and grandparents caring for their grandchildren. A family caregiver is defined as an adult family member, or another individual who is an informal provider of in-home and community care to an older individual who needs assistance for daily activities. It is important to know that while there may be a need in your community to find a caregiver for a person who lives alone and does not have a family caregiver, elders will not be eligible to hire a respite provider without a family caregiver under Title VI-Part C funds. Additionally, The Cheyenne and Arapaho Native American Caregiver Program provides services for caregivers, not the elders as well as grandparents caring for a child(s) under the age of 18 years. *(Grandparent must have legal guardianship of minor child).*

This program provides five areas of service for the caregiver, including respite care.

The offered support services include:

- Information
- Assistance
- Counseling, Training, Support Group
- Respite
- Supplemental Services

\*The NAC Program is an (8) week program\*

*A core value of the Native American Caregiver Support Services, is that the program does not replace the tradition of families caring for their elders. Rather, it provides support that strengthens a family's caregiver role.*

**If you are a family caregiver requesting assistance please fill out Part A. If you are a grandparent requesting services please fill out Part B of the application**



NAC Program  
10331 N. 2274 Rd.  
Office: (580)331-2351  
Fax: (405)422-8229  
[acarlon@c-a-tribes.org](mailto:acarlon@c-a-tribes.org)

## APPLICATION REQUIREMENTS

Application is to be filled out by Primary Care Provider who is requesting respite care assistance

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### Caregiver

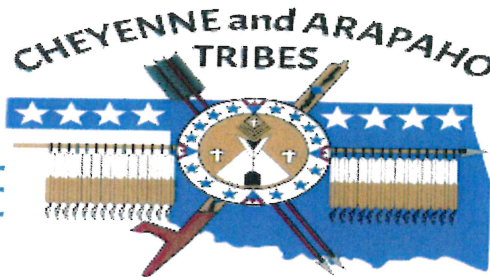
- Application filled out completely
- One form of Identification
- Current phone number the NAC Coordinator may reach you
- Caregiver is responsible for signing off on every invoice submitted by the respite provider before it will be approved by the NAC Coordinator
- Caregiver understand appointed respite provider may no reside with the Elder in which he/she is assisting.

### Elder

- One form of Identification
- Enrolled tribal member
- Dr. Statement

### Respite Care Provider

- Two forms of Identification
- W-9 form
- Intake form signed
- Contact number he/she can be reached
- Respite Provider understand he/she may not reside with elder at any time while participating in the Native American Caregiver Program



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## Cheyenne and Arapaho Native American Caregiver Elder Application

### **FAMILY CAREGIVER INFORMATION:** (Person requesting Respite care assistance)

Name: \_\_\_\_\_ D.O.B \_\_\_\_\_ SS: \_\_\_\_\_

Affiliated Tribe: \_\_\_\_\_ CDIB: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Physical Address: \_\_\_\_\_ Phone: \_\_\_\_\_

#### Relationship to Elder:

Spouse: YES— NO— Daughter/Son: YES—NO— OTHER: \_\_\_\_\_

### **ELDER INFORMATION:** (Person needing care)

Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ SS: \_\_\_\_\_

Age: \_\_\_\_\_ Affiliated Tribe: \_\_\_\_\_ CDIB: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Physical Address: \_\_\_\_\_ Phone: \_\_\_\_\_

### **NEEDS ASSISTANCE WITH PERSONAL CARE** (check all that apply)

Bathing \_\_\_\_\_ Eating \_\_\_\_\_ Walking \_\_\_\_\_ Dressing \_\_\_\_\_ Toileting \_\_\_\_\_ Driving \_\_\_\_\_

NEEDS SUPERVISION DUE TO ALZHEIMER'S/DEMENTIA: YES \_\_\_\_\_ NO \_\_\_\_\_

**(PLEASE REMEMBER TO PROVIDE UPDATED DR. STATEMENT)**

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_

Relationship to Elder: \_\_\_\_\_

### SERVICES OFFERED:

Program Info \_\_\_\_\_ Assist w/Services \_\_\_\_\_ Caregiver Advocate \_\_\_\_\_ Support Group \_\_\_\_\_  
Training \_\_\_\_\_ Emergency Services \_\_\_\_\_ RESPITE CARE \_\_\_\_\_

Family Caregiver Signature \_\_\_\_\_ Date \_\_\_\_\_

Elder Signature \_\_\_\_\_ Date \_\_\_\_\_

NAC Coordinator Signature \_\_\_\_\_ Date \_\_\_\_\_

Date of Completed Application \_\_\_\_\_

**\*\* Program requires elder to have a primary caregiver in order to request a respite care provider \*\***



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## RESPITE CONTRACT SERVICE AGREEMENT AND RESPONSIBILITIES

I, \_\_\_\_\_, agree to the terms of this agreement and enter into an agreement to provide contractual service with \_\_\_\_\_, a Family Caregiver for a period of no more than 8 week. I understand that the family caregiver with the approval of the Cheyenne and Arapaho Tribes of Oklahoma Native American Caregiver Program may from time to time renew this agreement.

I have the responsibility to provide respite care for a total of up to **80** hours during the 8 week program, with the maximum of **10** hours per week and agree to the rate of **\$7.25** per hour.

(With prior approval from the C&A Tribes Caregiver Program.)

I agree to the terms of this agreement with the following conditions:

- To assist the Family Caregiver by invoicing the C&A Tribes of Oklahoma that include hours, rate, and total amount due and making sure all required signatures are provided prior to submitting an invoice.
- Submit a W-9 IRS form with the initial agreement
- To assist the Family Caregiver to make applications with other agencies for long-term Respite Services, and
- That no change or modifications be made to this agreement

### Respite Contract Service Data

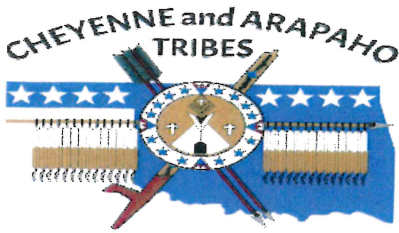
Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Cell: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Family Caregiver Data

Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Cell: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Administrative Approval

NAC Coordinator: \_\_\_\_\_ Date: \_\_\_\_\_



## Native American Caregiver Program Code of Ethics Worksheet

10331 N. 2274 Rd.  
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[acarlon@c-a-tribes.org](mailto:acarlon@c-a-tribes.org)

### I, AS A FAMILY CAREGIVER PROGRAM PROFESSIONAL SHALL:

*(For Respite care provider- Initial all and sign below)*

- \_\_\_\_\_ Maintain high level of personnel integrity and professional competence
- \_\_\_\_\_ Act always in a manner that reflects credibility upon my position.
- \_\_\_\_\_ Protect confidential information.
- \_\_\_\_\_ Report findings accurately, honestly, and make recommendation impartially.
- \_\_\_\_\_ Avoid situations where my professional judgement may be compromised.
- \_\_\_\_\_ Understand, promote, and implement the laws, regulations, guidelines and standards applicable to  
The Family Caregiver Program and specifically to my position, and
- \_\_\_\_\_ Uphold this Code of Ethics in the conduct of my duties and in my Professional associations.

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Respite Care Provider Signature

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Date

# Request for Taxpayer Identification Number and Certification

Give Form to the  
requester. Do not  
send to the IRS.

Go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9) for instructions and the latest information.

Print or type. See Specific Instructions on page 3.	1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.	
	2 Business name/disregarded entity name, if different from above	
	3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.  <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____ <b>Note:</b> Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner. <input type="checkbox"/> Other (see Instructions) ▶ _____	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):  Exempt payee code (if any) _____  Exemption from FATCA reporting code (if any) _____  <i>(Applies to accounts maintained outside the U.S.)</i>
	5 Address (number, street, and apt. or suite no.) See instructions.	Requester's name and address (optional)
	6 City, state, and ZIP code	
	7 List account number(s) here (optional)	

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

**Note:** If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number									
				-				-	
or									
Employer identification number									
				-					

## Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
- I am a U.S. citizen or other U.S. person (defined below); and
- The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

**Certification Instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign  
Here

Signature of  
U.S. person ▶

Date ▶

## General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

**Future developments.** For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9).

## Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

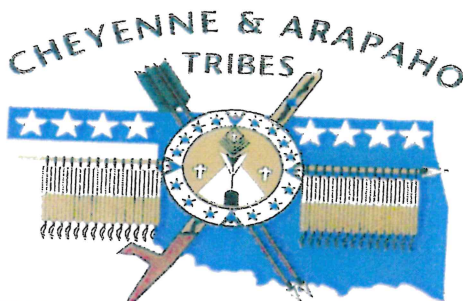
- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding*, later.

**Native American  
Caregiver Program**  
*Respite Care*



10331 N 2274 Rd.  
Clinton, OK 73601  
Phone: (580)331-2351  
Fax: (405) 422-8205

**Native American Caregiver Program Physicians Statement**

Date: \_\_\_\_\_

Dear Physician:

The Patient listed below is a participant of the Cheyenne & Arapaho Native American Caregiver Program. The participant must be in compliance with the Federal guidelines of the program. Federal guidelines states the elder receiving Respite Care must have at least two *Activities of Daily Living (ALD's)* impairments.

Please complete the information listed below for your patient.

Patient Name: \_\_\_\_\_

Needs Assistance with Personal Care: **(Check all that apply)**

- |                          |           |
|--------------------------|-----------|
| <input type="checkbox"/> | Bathing   |
| <input type="checkbox"/> | Dressing  |
| <input type="checkbox"/> | Eating    |
| <input type="checkbox"/> | Walking   |
| <input type="checkbox"/> | Toileting |
| <input type="checkbox"/> | Driving   |

Physician Printed Name: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_

Thank you for your time and prompt attention to this matter. If you have any questions, please do not hesitate to contact our office.

Sincerely,

Cheyenne & Arapaho Native American Caregiver Program